STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Investigation of Complaint IN00099832. Complaint IN00099832 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F309, F315 and F514. Survey date: 11/17/11 Facility number: 000321 Provider number: 155614 AIM number: 100286130 Survey team: Jennie Bartelt, RN Census bed type: SNF: 9 SNF/NF: 116 Total: 125 Census payor type: Medicare: 9 Medicaid: 94 Other: 22 Total: 125 Sample: 4 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provisions of federal and state law. For purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, the response and plan of correction constitutes Lincoln Hills Health Center's allegation of compliance in accordance with Section 7305 in the State Operations Manual.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on November 21, 2011 by Bev Faulkner, RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify the physician timely about a resident's change in condition. The deficient practice affected 1 of 4 residents reviewed related to change in condition followed by hospitalization in a sample of 4. (Resident B) Resident B experienced	F0157	The facility will continue to immediately inform the resident/responsible party and consult with the resident's physician when there is a significant change in the resident's physical status that may require an alteration in treatment.For Resident B, the facility did notify the MD on 9/3/11	12/13/2011

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	multiple episodes of vomiting and large bowel movements. The resident's abdomen was assessed as hard and distended at 6:00 a.m., and the assessment was not reported to the physician until 10:00 a.m. Findings include: The clinical record for Resident B was reviewed on 11/17/11 at 3:35 p.m. The record indicated the resident was receiving hospice services. Nurse's Notes signed by the hospice nurse indicated the resident was seen for routine hospice visits on 8/18/11, 8/22/11, and 8/31/11, and Nurse's Notes signed by facility staff indicated the resident was seen by the podiatrist on 8/19/11. The next nursing entry was "Nursing Follow-Up Documentation," dated 9/3/11, which indicated "Brief Description: N/V ABD [with line drawn through] Abdomen hard & distended." An instructional notation on the form indicated, "Use when any incidents, admissions/readmissions (for 72 hours), pertinents, abt [antibiotic] therapy and symptoms, acute illness/behavior problems, temps [temperatures], etc." Notes on the form indicated:		at 10:00 am regarding the distended abdomen and resident was sent to the hospital. Resident readmitted to facility at this time with no further problems noted.Any resident exhibiting gastrointestinal symptoms with a hard and distended abdomen has the potential to be affected. The 24-hour shift report has been reviewed to ensure that any residents experiencing gastrointestinal symptoms with a hard and distended abdomen have been assessed and the physician notified.A Policy and Procedure has been developed for Abdominal Assessment. All licensed nursing staff have been inserviced on the P & P related to Abdominal Assessment and the P & P for Physician Notification of Change of Condition.Nursing Managers will review the 24 hour shift reports daily to identify any residents experiencing a hard and distended abdomen to ensure appropriate assessment and timely physician notification has been completed. This audit will be completed daily times six months. Results of the above audits will be reported to the DON weekly. DON will ensure additional training and/or counseling is provided as necessary. A summary of the findings will be reported to the QA Committee quarterly for a minimum of two quarters. DON and Administrator to monitor	

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	9/3/11 12:40 a.m., "Res lg [large] undigested emesis & lg pasty BM [bowel movement]. Full bed strip, T 99.3 ax. Cleaned [arrow pointing up] per 3 staff [symbol for with] HOB [head of bed] [arrow pointing up]. Supp [suppository] Phenergan 25 mg & 650 mg Tyl [Tylenol] supp given @ this time." 9/3/11 2:30 a.m., "Res lg liq [liquid] brown emesis @ this time [symbol for with] some undigested food. Lg pasty BM @ this time again. T 98 ax [axillary] Cleaned [arrow pointing up] again. HOB [arrow pointing up]. Cont [continue to monitor]." 9/3/11 6:00 a.m., "Res has had 3 [illegible word] lg liq emesis [symbol for with] undigested food again. T 99.1 Ax. Lg pasty BM again. Tyl supp 650 again. Will cont to monitor. BS [bowel sounds] + [positive] all 4 quads and wife notified of res condition." 9/3/11 6:00 a.m. [second entry at this time], "Abd hard and distended." 9/3/11 10:00 a.m., "Resident sent to [name of local hospital] to be evaluated. The next entry in the Nurse's Notes was 9/3/11 at 10:00 a.m., and indicated, "Res.			

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	[resident] n/v [nausea and vomiting] and a very distended abdomen. Call placed to [name of hospice] who called [name of physician]. He advised to send res. to [name of local hospital] for evaluation....V/S [vital signs] 130/78 [blood pressure], 72 [pulse], 20 [respirations] 98.7 [temperature], 94% [oxygen saturation]...." A hospital History and Physical, dictated 9/4/11, indicated the resident was admitted to the hospital on 9/3/11 and underwent sigmoid colectomy for volvulus. During interview on 11/17/11 at 5:15 p.m., the Director of Nursing (DON) indicated changes in condition for Resident B would have been reported to the hospice, who would report to the physician. This federal tag is related to Complaint IN00099832. 3.1-5(a)(2) 3.1-5(a)(3)			

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure a resident with onset of gastrointestinal symptoms was thoroughly assessed and change in condition reported timely to the physician for 1 of 4 residents reviewed related to change in condition followed by hospitalization in a sample of 4. (Resident B) Findings include: The clinical record fro Resident B was reviewed on 11/17/11 at 3:35 p.m. The record indicated the resident was receiving hospice services. Nurse's Notes signed by the hospice nurse indicated the resident was seen for routine hospice visits on 8/18/11, 8/22/11, and 8/31/11, and Nurse's Notes signed by facility staff indicated the resident was seen by the podiatrist on 8/19/11. A "Nursing Follow-Up Documentation," dated 9/3/11, indicated "Brief Description: N/V ABD [with line drawn through] Abdomen hard & distended." An instructional notation on the form	F0309	The facility does provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.Resident B was assessed for gastrointestinal symptoms on 9/3/11 at 12:40 am, 2:30 am, 6:00 am and 10:00 am at which time the facility did notify the MD and resident was sent to the hospital. Resident readmitted to facility at this time with no further problems noted.Any resident exhibiting gastrointestinal symptoms with a hard and distended abdomen has the potential to be affected. The 24-hour shift report has been reviewed to ensure that any residents experiencing gastrointestinal symptoms with a hard and distended abdomen have been assessed and physician notified.A Nursing Policy and Procedure has been developed for Abdominal Assessment. All licensed nursing staff have been inserviced on the P & P related to Abdominal Assessment and the P & P for Physician Notification of Change of Condition.Nursing Managers	12/13/2011

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	indicated, "Use when any incidents, admissions/readmissions (for 72 hours), pertinents, abt [antibiotic] therapy and symptoms, acute illness/behavior problems, temps [temperatures], etc." Notes on the form indicated: 9/3/11 12:40 a.m., "Res lg [large] undigested emesis & lg pasty BM [bowel movement]. Full bed strip, T 99.3 ax. Cleaned [arrow pointing up] per 3 staff [symbol for with] HOB [head of bed] [arrow pointing up]. Supp [suppository] Phenergan 25 mg & 650 mg Tyl [Tylenol] supp given @ this time." 9/3/11 2:30 a.m., "Res lg liq [liquid] brown emesis @ this time [symbol for with] some undigested food. Lg pasty BM @ this time again. T 98 ax [axillary] Cleaned [arrow pointing up] again. HOB [arrow pointing up]. Cont [continue to monitor]." 9/3/11 6:00 a.m., "Res has had 3 [illegible word] lg liq emesis [symbol for with] undigested food again. T 99.1 Ax. Lg pasty BM again. Tyl supp 650 again. Will cont to monitor. BS [bowel sounds] + [positive] all 4 quads and wife notified of res condition." 9/3/11 6:00 a.m. [second entry at this		will review the 24 hour shift reports daily to identify any residents experiencing gastrointestinal symptoms with a hard and distended abdomen to ensure appropriate assessment and timely physician notification has been completed. This audit will be completed daily times six months. Results of the above audits will be reported to the DON weekly. DON will ensure additional training and/or counseling is provided as necessary. A summary of the findings will be reported to the QA Committee quarterly for a minimum of two quarters. DON and Administrator to monitor.	

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	time], "Abd hard and distended." 9/3/11 10:00 a.m., "Resident sent to [name of local hospital] to be evaluated. The next entry in the Nurse's Notes was 9/3/11 at 10:00 a.m., and indicated, "Res. [resident] n/v [nausea and vomiting] and a very distended abdomen. Call placed to [name of hospice] who called [name of physician]. He advised to send res. to [name of local hospital] for evaluation....V/S [vital signs] 130/78 [blood pressure], 72 [pulse], 20 [respirations] 98.7 [temperature], 94% [oxygen saturation]...." A hospital History and Physical, dictated 9/4/11, indicated the resident was admitted to the hospital on 9/3/11 for sigmoid colectomy for volvulus. During interview on 11/17/11 at 5:15 p.m., the Director of Nursing (DON) indicated Resident B had constipation, and it was not unusual for Resident B to have large stools following administration of a laxative. She reviewed the resident's record at this time and indicated the resident was on a routine daily stool medication, but had not received a laxative medication prior to the 9/3/11 episode of large bowel movement and emesis. The DON indicated the wording			

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	"Abdomen hard & distended" had been added to the "Nursing Follow-up Documentation" after the nurse assessed the resident's abdomen on 9/3/11 at 6:00 a.m. The DON indicated the facility had no policy on what a nurse should assess when a resident developed vomiting and large pasty bowel movements. The DON indicated changes in condition for Resident B would have been reported to the hospice, who would report to the physician. During interview on 11/17/11 at 6:15 p.m., LPN #15 indicated if a resident had any change, she would first assess all vital signs. She indicated for a resident with gastrointestinal symptoms, she would assess bowel sounds and for abdominal distention. During interview on 11/17:20 /11 at 6:20 p.m., LPN #3 and LPN #7 indicated they would assess a resident's vital signs with any change. They indicated they would assess bowel sounds for a resident with vomiting, and LPN #3 indicated she would also measure the resident's abdominal girth. Review of the American Medical Directors Association (AMDA) "Know-it-all Before You Call Data Collection System, 2010" indicated for			

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	"Nausea/Vomiting, Physical Data: vital signs; abdominal evaluation including bowel sounds, distension, and tenderness; rectal evaluation, including pain or tenderness, masses, or hard stool in rectum (if signs of constipation or fecal impaction); presence of blood (gross or occult) or undigested food in vomitus; description of vomitus (color, amount); inspect for jaundice and bruises." This federal tag is related to Complaint IN00099832. 3.1-37(a)			
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to ensure a resident with history of urinary tract infection was assessed thoroughly when the resident	F0315	The facility does ensure that resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to	12/13/2011

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	began to experience signs and symptoms of urinary tract infection and elevated temperatures. The deficient practice affected 1 of 4 residents reviewed related to change in condition followed by hospitalization in a sample of 4. (Resident D) Findings include: The clinical record for Resident D was reviewed on 11/17/11 at 1:40 p.m. The record indicated the resident's diagnoses included, but were not limited to, urinary tract infection. The resident received all nutrition and hydration by gastrostomy tube, and the resident was incontinent. Nurse's Notes, dated 11/2/11 at 10:00 a.m., indicated, "Foul smelling urine noted notified supervisor & MD [physician] NO [new order] received obtain UA C&S [urinalysis with culture and sensitivity] next lab day notified [name] RP [responsible party] expressed understanding." Nurse's Notes indicated a urine specimen was obtained by straight catheter at 2:00 a.m., on 11/3/11 and sent to the lab. Nurse's Notes indicated the results of the urinalysis with culture and sensitivity was received on 11/5/11 at 2:50 p.m., and the resident's physician ordered an antibiotic to which the organism in the urine was susceptible.		restore as much normal bladder function as possible.Resident D was discharged from facility on 11/7/11.Any resident with a history of urinary tract infection who are experiencing signs and symptoms of urinary tract infection have the potential to be affected. The 24-hour shift report has been reviewed and any residents experiencing signs or symptoms of urinary tract infection have been assessed. Nursing Policy and Procedure for Assessment of Urinary Tract Infection has been revised to include completion of vital signs at the onset of symptoms; at the time of elevated temperature and/or at the time of worsening of any symptoms.All licensed nursing staff have been inserviced on revised P & P for Assessment of Urinary Tract Infection.Nursing Managers will audit the 24-hour shift report daily to ensure that any residents exhibiting signs and symptoms of urinary tract infection are appropriately assessed. Audits will be completed for a minimum of six months. Results of these audits will be reported to the DON weekly. DON will ensure additional training and/or counseling is provided as necessary. A summary of the findings will be reported to the QA Committee quarterly for a minimum of two quarters. DON and Administrator to monitor.	

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	Documentation failed to indicate the resident's vital signs (temperature, blood pressure, pulse, respirations, or oxygen saturation) was measured from 11/2/11 until 11/5/11. A "Nursing Follow-Up Documentation," dated 11/2/11, indicated, "Brief Description: UA C&S R/T [related to] foul odor." An instructional notation on the form indicated, "Use when any incidents, admissions/readmissions (for 72 hours), pertinents, abt [antibiotic] therapy and symptoms, acute illness/behavior problems, temps [temperatures], etc." Notations on the form were as follows: 11/3/11 at 2:00 a.m., indicated the resident's urine was obtained by straight catheter with "strong odor and very cloudy...." 11/3/11 at 2:00 p.m., "Odor continues...." 11/3/11 at 5:00 p.m., "...Odor still noted to be foul...." 11/4/11 at 3:00 a.m., "Urine remains strong odor. Voiding [symbol for without] difficulty...." 11/4/11 at 1:00 p.m., "...foul odor			

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	remains." :00 p.m., 11/4/11 at 5:00 p.m., "...Res. voids [symbol for without] difficulty [symbol for with] foul odor noted. Will monitor." An untimed notation on the form, dated 11/5/11, indicated the resident's temperature was 96.9, and a notation on 11/5/11 at 9:00 a.m. indicated the temperature was 97.4 degrees. No other documentation on the form indicated assessments related to the potential urinary tract infection. A "Nursing Follow-Up Documentation," dated 11/5/11, indicated, "Brief description: Ampicillin 500 mg per g-tube [gastrostomy tube] TID [three times daily] X [times] 10 days....Monitor temp [temperature] qs [every shift]." Notations on the form indicated the temperature on 11/6/11 at 12 midnight was 97.8, at 10:15 a.m., 98.2, and at 2:00 p.m., 99.1 degrees. A notation on 11/6/11 at 8:00 p.m., indicated, "Res [resident] appears diaphoretic, temp [temperature]102.4, prn [as needed] Tylenol given @ 8:00 p.m. for [arrow pointing up] increased fever." A Nurse's Note for 11/6/11 at 8:00 p.m., indicated, "...Will monitor resident's temp			

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LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN47150

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	closely...." A Nurse's Note for 11/6/11 at 9:30 p.m., indicated, "Rechecked temperature, read 101.7. [name of physician] notified, MD stated to remain on ABT [antibiotic] as long as she is susceptible to it...." A notation on the "Nursing Follow-Up Documentation," dated 11/5/11, "Brief description: Ampicillin 500 mg per g-tube [gastrostomy tube] TID [three times daily] X [times] 10 days....Monitor temp [temperature] qs [every shift]," indicated for 11/7/11 at 12 midnight, "T 99.1 oral gave Tyl prn as ordered. MD aware of temp & change in condition on ABT R/T UTI." Other notations indicated, 11/7/11 at 5:00 a.m., "T 101.9 oral. Cont. [continue] to monitor," 11/7/11 at 5:15 a.m., R/T T 101.9 oral. Adm [administered] Tylenol at this time & cont [symbol for with] wet cool wash cloths to forehead & armpits," 11/7/11 at 8:00 a.m., "T 97.3 will continue to monitor, " 11/7/11 at 8:30 a.m., "[name of physician] here & advised him resident's temp @ 5:15 a.m. 101.9. [Name of physician] states continue Ampicillin temp likely R/T UTI." Documentation failed to indicate the resident was assessed on 11/7/11 between midnight and 5:00 a.m.,between 5:00 a.m.			

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	and 8:00 a.m., and between 8:00 a.m. and 11:30 a.m. Nurse's Notes for 11/7/11 at 11:30 a.m., indicated, "BS [blood sugar] 435 max [maximum] sliding scale given. ADON [Assistant Director of Nursing] and MD notified will re-check in 30 minutes." Nurse's Notes for 11/7/11 at 12:00 p.m., indicated, "Skin cool and clamy [sic] B/P 90/58, P 100, T 103.1, R 32, O2 sats [oxygen saturation] 89% on RA [room air] MD Notified NO [new order] 1. Acetaminophen supp [suppository] 650 mg q 4 h [every four hours] [arrow pointing up] fever 2. Duoneb q 4 h prn [as needed] for SOA [shortness of air] Check O2 pre and post tx [treatment] O2 at @ 2 LPM [liters per minute] to maintain at or above 90% 3. Obtain CXR [chest x-ray]...." Nurse's Notes for 11/7/11 at 12:15 p.m., indicated, "AC [check mark] [blood sugar check] 461 call placed to MD left voicemail awaiting return phone call." Nurse's Notes for 11/7/11 at 1:55 p.m., indicated, "[name of physician] returned call. N.O. D/C [discontinue] Ampicillin, Duoneb q 4 [symbol for hours], Rocephin [antibiotic] 1 gm IM [intramuscular injection], [symbol for no] N.O. R/T			

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	[arrow pointing up] blood sugars. Call placed to daughter & we were told she is on her way to facility." Nurse's Notes for 11/7/11 at 2:00 p.m., indicated, "Dgtr [daughter] arrived at facility requested res be sent to [name of local hospital] ER [emergency room] B/P 68/40, BS 423, notified ADON, DON [Director of Nursing], MD NO may send to [name of local hospital] ER for evaluation & tx." Hospital History and Physical, dictated 11/8/11, indicated Resident D was admitted to the hospital on 11/7/11 with "Reason for Admission: Sepsis with dehydration and renal failure, hypotension, diarrhea, positive Clostridium difficile and urinary tract infection." During interview on 11/17/11 at 5:15 p.m., the DON indicated she had been to Resident D's room about 12:20 p.m.,on 11/7/11, and also at the time the resident was transferred to the hospital at 2:00 p.m. The DON indicated the resident had become less responsive between the DON's first and second visits. She indicated the nurse obtained a full set of vital signs when the resident's skin became cool and clammy, which was a change in condition. The DON indicated			

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	this was not necessary previously, because the resident had not had a change of condition. The DON indicated the facility would have sent the resident to the emergency room even if the resident's daughter had not been present to make the request. During interview on 11/17/11 at 6:30 p.m., the DON indicated when a resident potentially has a urinary tract infection or is on antibiotics for urinary tract infection, she would expect a nurse to check only the resident's temperature. She indicated she would not expect a nurse to check a resident's other vital signs or complete other system assessments "unless something else starts to occur." Review of Lippincott's Pocket Manual of Nursing Practice, second edition, indicated for "Urinary Tract Infection in Adults, Lower," "Assessment: 1. Dysuria, frequency, urgency, nocturia; 2. Suprapubic pain and discomfort; 3. Hematuria; 4. May be asympomatic; Gerontologic Alert: The only sign of UTI in the elderly may be mental status change." Review of the American Medical Directors Association (AMDA) "Know-it-all Before You Call Data Collection System, 2010" indicated to			

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	following assessments for "Fever, Physical Data: Vital signs; Fever patterns (continuous, intermittent, etc.); Any signs of alternating fever and rigors (shaking, chills, fatigue, or pain), diaphoresis; Signs of inflammation or infection at specific locations (joints, lungs, skin, etc.); Any significant cardiac, lung, or abdominal findings, headache, muscle aches, clinical sigh of dehydration (postural pulse difference - increase from lying down to sitting or standing or 30 beats per minute or more, tachycardia, rapid weight loss, cracked lips, thirst, new onset or increased confusion, fever), loss of appetite. 3.1-41(a)(2)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure the resident's record was accurate related to tube feedings for 1 of 4 residents whose	F0514	The facility does maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	12/13/2011

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	records were reviewed for accuracy of documentation in a sample of 4. (Resident D) Findings include: The clinical record for Resident D was reviewed on 11/17/11 at 1:40 p.m. The record included an Enteral Flow Record for November 2011. The Enteral Flow Record indicated the resident received a tube feeding of Glucerna 1.5 to be infused by pump at 50 cc per hour. The Enteral Flow Record also indicated the resident received 120 cc of water flushes before medications at 6:00 a.m., 9:00 a.m., 2:00 p.m., and 7:00 p.m. Documentation on the Enteral Flow Record failed to indicate the tube feeding and water flushes were administered on the first and second nursing shifts (6:00 a.m. to 2:00 p.m. and 2:00 p.m. to 10:00 p.m.) on 11/6/11. During telephone interview on 11/17/11 at 6:25 p.m., LPN #11 indicated she had administered Resident D's tube feeding and water flushes when she worked first and second shifts on 11/6/11, but she had not documented the information on the Enteral Flow Record. This federal tag is related to Complaint IN00099832.		accurately documented; readily accessible; and systematically organized.Resident D discharged from the facility on 11/7/11. All residents receiving enteral feedings have the potential to be affected. The enteral flow records for those residents receiving enteral feedings have been reviewed for completion.LPN #11 has been counseled regarding accurate completion of enteral flow records.All licensed nursing staff have been inserviced regarding accurate completion of enteral flow records.Nursing Managers will audit enteral flow records weekly times four weeks, monthly times one month and then quarterly times one quarter.Results of these audits will be reported to the DON weekly. DON will ensure that additional training and/or counseling is provided as necessary. A summary of the findings will be reported to the QA Committee quarterly for a minimum of two quarters.DON and Administrator to monitor.	

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	3.1-50(a)(1) 3.1-50(a)(2)			